Youth Mental Health Services

MONTANA
Department of Public Health & Human Services

September 2011

This publication supersedes all previous Children's Mental Health Services Medicaid manuals. First publication by the Montana Department of Public Health and Human Services was October 2003.

New original publication is dated September 2011.

The purpose of this manual is to assist Medicaid enrolled providers who serve youth with mental health needs. The manual contains information intended to assist the reader in understanding Medicaid funded mental health services for youth, and to explain billing and other requirements for services provided. Because this is a general guide, it was written to serve as an aid to enrolled providers in understanding various processes important to the provision of children's mental health services. This manual does not substitute for State or Federal rule, manuals incorporated in ARM, or other professional resources.

NPI/API:

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Key Contacts

Hours for Key Contacts are 8 a.m. to 5 p.m. Monday through Friday (Mountain Standard Time), unless otherwise stated. The telephone numbers designated **only** "In-state" will not work outside Montana.

Claims

Send paper claims to:
Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

Client Eligibility

FaxBack
(800) 714-0075 (24 hours)
Automated Voice Response System (AVRS)
(800) 714-0060 (24 hours)
Montana Access to Health Web Portal
http://mtaccesstohealth.acs-shc.com/mt/general/home.do
Medifax EDI
(800) 444-4336, X 2072 (24 hours)

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call.
(406) 444-5283

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719	In- and out-of-state
(406) 442-1837	Helena
(406) 442-4402	Fax

ATTN: MT EDI
ACS
P.O. Box 4936
Helena, MT 59604

MTEDIHelpdesk@ACS-inc.com

Passport Client Help Line

Clients who have general Medicaid questions may call the Client Help Line:
(800) 362-8312

Send written inquiries to:
Passport to Health
P.O. Box 254
Helena, MT 59624-0254

Prior Authorization

For questions regarding prior authorization and continued stay review for selected mental health services:

Magellan Medicaid Administration
(previously First Health)

(800) 770-3084	Phone
(800) 639-8982	Fax
(800) 247-3844	Fax

https://montana.fhsc.com/

Mail to:
Magellan Medicaid Administration
4300 Cox Road
Glen Allen, VA 23060

For prior authorization of pharmacy services, contact Mountain-Pacific Quality Health.

Mountain-Pacific Quality Health

The prescriber (e.g., physician) or pharmacy provider may submit requests to the Drug Prior Authorization Unit by mail, telephone, or fax to:

(406) 443-6002 Phone
(800) 395-7961 Phone
(406) 513-1928 Fax
(800) 294-1350 Fax

Mail to:

Drug Prior Authorization Unit
Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602

Provider's Policy Questions

For policy questions, contact the DPHHS Children's Mental Health Bureau.

(406) 444-4545

www.dphhs.mt.gov/mentalhealth/children/

Provider Relations

For questions about enrollment, eligibility, payments, denials, general claims questions, or to request provider manuals or fee schedules:

(800) 624-3958 In- and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send e-mail inquiries to:

MTPRHelpdesk@ACS-inc.com

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

For Passport enrollment or caseload questions:

(800) 362-8312

Send Passport correspondence to:

Passport to Health
P.O. Box 254
Helena, MT 59624-0254

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Third Party Liability

For questions about private insurance, Medicare, or other third-party liability:

(800) 624-3958 In- and out-of-state
(406) 442-1837 Helena
(406) 442-0357 Fax

Send written inquiries to:

Third Party Liability Unit
P.O. Box 5838
Helena, MT 59604

Key Websites

Web Address	Information Available
ACS EDI Gateway www.acs-gcro.com/	ACS EDI Gateway is Montana's HIPAA clearinghouse. From the *EDI Gateway Clients* tab, select the *Montana Department of Public Health and Human Services* link for information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides • FAQs and links
Centers for Disease Control and Prevention (CDC) www.cdc.gov/vaccines	Immunization and other health information
Magellan Medicaid Administration https://montana.fhsc.com/	• Clinical guidelines manual for utilization management. • Utilization review forms • Utilization review portal for web submission
Children's Mental Health Bureau (CMHB) Website http://www.dphhs.mt.gov/mentalhealth/children/	• Bureau information and program descriptions • Provider manuals and forms • Information for families and youth
Healthy Montana Kids (HMK) http://hmk.mt.gov	• Information on Healthy Montana Kids (HMK)
Provider Information Website www.medicaidprovider.hhs.mt.gov **Montana Access to Health (MATH) Web Portal** https://mtaccesstohealth.acs-shc.com/mt/general/home.do	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Passport and Team Care information • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts and more
Public Assistance Toolkit https://dphhs.mt.gov/	Select *Human Services* for information on: • Medicaid: Client information, eligibility information, and provider information • Montana Access Card • Provider Resource Directory • Third Party Liability Carrier Directory
Secretary of State www.sos.mt.gov **ARM Home Page** www.mtrules.org	• Secretary of State website • Administrative Rules of Montana
Washington Publishing Company www.wpc-edi.com	• EDI implementation guides • HIPAA implementation guides and other tools • EDI education

Enrollment Provider Numbers

Reimbursement for mental health services through Medicaid requires enrollment as a Medicaid provider prior to services being provided. ACS enrolls mental health providers. Information concerning enrollment is available at http://medicaidprovider.hhs.mt.gov/. Providers without Internet access may contact Provider Relations at 1-800-624-3958 (in- and out-of-state) or (406) 442-1837 (Helena). A provider must have an active provider number in order to submit a claim for reimbursement. Mental health providers must use their National Provider Identifier (NPI) and taxonomy number to bill for services unless they are an atypical mental health provider type. Atypical mental health provider types include social workers, therapeutic group homes, and therapeutic family care providers. Atypical mental health providers may bill using their NPI and taxonomy number or the Atypical Provider Identifier (API) number assigned to them by ACS on enrollment.

Some providers may have different provider numbers assigned for different types of mental health services they are providing. If a provider has multiple provider numbers, it is important to make sure to use the correct provider number for the services being billed.

Coding Requirements

When coding for Montana Medicaid, be aware that Current Procedural Terminology (CPT) codes and modifiers, including their respective definitions, are developed by the American Medical Association for providers to describe their services numerically for claim submission to insurers.

Montana DPHHS requires the use of uniform procedure and diagnosis coding on all claims. The procedure code must accurately reflect the time spent with the patient.

Fees and covered codes for each provider type are available on the ACS website at http://medicaidprovider.hhs.mt.gov/.

The Department's goal is to pay claims as quickly and efficiently as possible. To achieve this goal, a computer processes claims. This automated method does not include review by medical personnel or detailed evaluation for appropriate billing procedures.

The automated system detects many billing errors and denies claims accordingly. However, providers should not rely on this process to ensure all billing is correct. **Providers are responsible for billing their services correctly.** Standard use of coding conventions, particularly those established in the most current editions of the ICD-9-CM and CPT-4 and HCPCS Level II manuals are required of the provider when billing Medicaid. Providers should become familiar with these manuals because DPHHS relies on them when setting its coding policies.

ARM 37.85.413 states that employees of the Department, or of any contractor or agent of the Department, may give a provider general information as to what codes are available for billing under Medicaid for a particular service or item being provided. However, the provider retains responsibility for selecting and submitting the proper code to describe the service or item provided.

If an employee of the Department or of a contractor or agent of the Department suggests, recommends, or directs the provider to use a particular code from the choices available or gives other specific coding advice, the provider may not rely on such advice unless the advice is provided in writing before the provider submits a claim for the service or item.

Do not assume that payment of a claim means the service was billed or paid correctly. All claims are subject to post-payment review and possible recovery of overpayments.

Provider Manuals

Detailed information on billing, reimbursement, limitations and other requirements is contained in the provider manuals available for each provider type on the Medicaid provider website. Those provider manuals take precedence over this manual where conflicts may exist with other Montana Medicaid services. All providers also have access to the *General Information for Providers* manual through the website http://medicaidprovider.hhs.mt.gov/.

If you bill for services on the CMS-1500 and need assistance, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf.

If you bill for services on the UB-04 claim form and need assistance, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructionsub.pdf.

Providers are required to provide services in accordance with Federal regulations, Montana State law, Administrative Rules, and any applicable licensure standards. In the event of a conflict between Federal regulations, Montana State law, Administrative Rules, or any applicable licensure standards and this manual, the former will prevail.

The Department only makes payment for services which are medically necessary as determined by the Department or by the designated review organization.

For medical necessity information, refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management* at https://montana.fhsc.com/ or http://www.dphhs.mt.gov/mentalhealth/children/

Third Party Coverage and Medicare

When they exist, other financial resources must be identified on the claim form. The other resource must be billed before the provider files a claim with ACS. When billing ACS as the secondary payer, the provider must report the amount paid by the other resource or submit a photocopy of the statement of denial from the other resource. The denial must list the insurance company name, patient name, date of service, amount billed and complete reason for denial. Refer to the *General Information for Providers* available at http://medicaidprovider.hhs.mt.gov/.

Claims for individuals who are eligible for both Medicare and Medicaid will be paid taking into consideration the psychiatric reduction from Medicare. A Medicare mental health crossover claim will price at either the amount Medicare allowed minus the Medicare paid or the amount Medicaid allowed minus the Medicare paid, whichever is lower.

Surveillance/Utilization Review

Payment of a claim does not mean it was paid correctly. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. The Department is charged by Federal and State law to identify, investigate, and refer to the Medicaid Fraud Control Unit of the Department of Justice all cases of suspected fraud or abuse in Medicaid by either providers or clients. Refer to the *General Information for Providers* manual for additional information and requirements regarding surveillance/utilization review.

Coverage

Mental health services delivered by the provider types listed below are covered under Montana Medicaid for youth as defined in ARM 37.87.102. For detailed information on reimbursed services, see the appropriate provider category under the *Services* section of this manual.

Program	Coverage	Prior Authorization	Billing Form
Inpatient Hospital	Y	Y	UB-04
Hospital Outpatient/Emergency Room	Y	N	UB-04
Psychiatric Residential Treatment Facility	Y	Y	UB-04
Partial Hospitalization	Y	Y	UB-04
Therapeutic Group Home	Y	Y	CMS-1500
Therapeutic Foster Care	Y	Y	CMS-1500
Mental Health Centers	Y	Some	CMS-1500
Therapeutic Family Care	Y	Y	CMS-1500
Physicians	Y	Some	CMS-1500
HCBS-PRTF Waiver	Y	Y	CMS-1500
Psychiatrists	Y	N	CMS-1500
Psychologists	Y	N	CMS-1500
Related Laboratory and X-Ray	Y	N	CMS-1500
Mid-Level Practitioners	Y	N	CMS-1500
Social Workers	Y	N	CMS-1500
Licensed Professional Counselors	Y	N	CMS-1500
Pharmacy & Related Lab Services	Y	Some*	Point-of-sale or MA-5
Case Management	Y	N	CMS-1500
Personal Care	Y	N	CMS-1500
Indian Health Services	Y	N	UB-04
Federally Qualified Health Centers	Y	N	UB-04
Rural Health Clinics	See p. 23	N	UB-04

*Some prescriptions require prior authorization.

Covered Diagnoses

All mental health Medicaid services must be medically necessary for the treatment of the mental health diagnosis entered on the claim form. Refer to the Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management* for medical necessity criteria or go to the Magellan Medicaid Administration website https://montana.fhsc.com

Outpatient Therapy Services

All Medicaid youth with a diagnosis from the current ICD-9-CM can receive an unlimited number of group therapy sessions and up to 24 sessions of individual and/or family outpatient therapy in a state fiscal year. All outpatient therapy claims must include a mental health diagnosis. To receive additional individual and/or family outpatient therapy in excess of 24 sessions, the youth must be determined to have a serious emotional disturbance (ARM 37.87.303).

Inpatient and Outpatient Hospital and Partial Hospital Services

Youth are not required to have a serious emotional disturbance to receive outpatient or inpatient hospital services. However, youth must have a serious emotional disturbance (SED) to receive partial hospital program services. For outpatient and inpatient hospital services, the physician is responsible for deciding whether the client should be admitted as an inpatient. Inpatient hospital admissions are subject to retrospective review by the Department or the Department's designated review organization to determine whether the inpatient admission was medically necessary for Medicaid payment purposes.

Except for inpatient and outpatient hospital services, the youth must have been determined to have a serious emotional disturbance to receive all other covered mental health services. Mental health services for youth are limited to services that treat the primary or principal diagnosis when it is a "covered" diagnosis. The ACS claims processing system will only accept valid **ICD-9-CM** diagnosis codes. A crosswalk between the covered ICD-9-CM codes and DSM-IV codes is available at http://medicaidprovider.hhs.mt.gov/ or by contacting ACS Provider Relations.

Prior Authorization and Continued Stay Review

Certain mental health services listed in this manual always require prior authorization. Claims for those services rendered to Medicaid beneficiaries will be denied payment without prior authorization.

All requests for prior authorization and continued stay authorization must be sent to:

Magellan Medicaid Administration (previously First Health Services)
1-800-770-3084 Phone
1-800-639-8982 or 1-800-247-3844 Fax

The Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management,* including forms to request prior authorized services, is available at the Magellan Medicaid Administration website https://montana.fhsc.com. Click on the *Providers* tab and choose

Youth Program and either the *Manual*s or *Forms* link. The manual is also available on the Children's Mental Health Bureau website at www.dphhs.mt.gov/mentalhealth/children.shtml.

Claims for services that require prior authorization must have the prior authorization number indicated in the appropriate field on the claim form. Providers must bill Medicaid according to the information supplied on the prior authorization. Each line on the claim must match the line information on the authorization with respect to dates of service, procedure code, and units of service.

A Certificate of Need (CON) that complies with the requirements of 42 CFR, Part 441, Subpart D must be completed for all Medicaid beneficiaries under age 21 who request the following services:

- Psychiatric Residential Treatment Facility (PRTF)
- Acute Care General Hospital, Psychiatric Hospital, and Distinct Part Psychiatric Unit of an Acute Care General Hospital (Acute)
- Partial Hospital Program
- Therapeutic Group Home (TGH)
- Therapeutic Foster Care (TFOC Mod and Permanency)
- Therapeutic Family Care (TFC Mod)

The CON is obtained by a team that includes a physician, who has competency in the diagnosis and treatment of mental illness, and has knowledge of the individual's condition. A licensed mental health professional must complete the CON. A case manager's signature is not required on the CON. However, the person who completes the CON must sign the form and provide contact information. The team must certify the services requested will be provided in the least restrictive environment that will meet the youth's needs and that the services can be reasonably expected to improve the youth's condition or prevent further regression.

For providers who bill using the CMS-1500 claim form, if the prior authorization issued has 3 lines of service, the provider must bill with 3 individual lines on the claim form that match the 3 lines on the prior authorization. A prior authorization number may have up to 21 claim lines.

For providers who bill using the UB-04 claim form, if the prior authorization issued has three lines of service, the provider must bill 3 individual UB-04 claim forms for each line of service indicated on the prior authorization.

If you bill for services on the CMS-1500, and need assistance, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf.

If you bill for services on the UB-04 claim form, and need assistance, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructionsub.pdf.

Those mental health services not requiring prior authorization are still subject to retrospective review by the Department for medical necessity and appropriateness.

Cost Sharing and Client Responsibility

Children (*under age 18*), **pregnant women, and nursing home residents are exempt from Medicaid cost sharing.**

Providers are required to accept, as payment in full, the amount paid by the Montana Medicaid program for a service provided to an eligible client. A provider may bill a client for non-covered services if: 1) the provider has informed the client in advance of providing the services that Medicaid will not cover the services; 2) the provider has informed the client that private payment will be required, and 3) the client has agreed to pay privately for the services. The client must be informed of the specific service and date of service for which he/she will be responsible for payment. Non-covered services are those that may not be reimbursed for the particular client by the Montana Medicaid program under any circumstances. Covered services are those that may be reimbursed by the Montana Medicaid program for the particular client if all applicable requirements, including medical necessity, are met.

A provider may not bill a client after Medicaid has denied payment for covered services because the services are not medically necessary unless the provider specifically informed the client in advance of providing the services that the services are not considered medically necessary under Medicaid criteria, that Medicaid will not pay for the services and that the client will be required to pay privately for the services, and the client has agreed to pay privately for the services. The agreement to pay privately must be based upon definite and specific information given by the provider to the client indicating that the service will not be paid by Medicaid. **The provider may not bill the client when the provider has informed the client only that Medicaid may not pay or where the payment agreement is contained in a form that the provider routinely requires clients to sign.**

A provider may not bill a client for services when Medicaid does not pay as a result of the provider's failure to comply with applicable enrollment, prior authorization, billing or other requirements necessary to obtain payment (ARM 37.85.406(11)).

Eligibility Information

Whenever possible, the provider should view the patient's ID card and verify eligibility information using one of the methods described below.

Providers can access Medicaid information by using the Montana Access to Health (MATH) web portal. MATH provides the tools and resources to help health care providers conduct business electronically. Providers must complete a Montana Enrollment Form and register to use the MATH web portal. Providers may register by clicking the web registration link on the left side of that page to register. New providers and providers who have not already completed a Montana Enrollment Form, may click on the Provider Enrollment link for step-by-step instructions.

Another option is to call the Automated Voice Response System (AVRS) at 1-800-714-0060 or FaxBack at 1-800-714-0075. AVRS will notify you as to whether a Medicaid client has eligibility for a particular date of service. Providers must have their provider number (NPI/API), client identification number, and date of service available. FaxBack faxes a report of the client's eligibility

including managed care details, insurance coverage, Medicare coverage, etc. To sign up for FaxBack, call ACS at 1-800-624-3958 in- and out-of-state and (406) 442-1837 in Helena. Providers must have their NPI/API and fax number ready when they call.

Providers will be given an audit number when contacting ACS and the AVRS for eligibility. Providers will be responsible for keeping the audit number on file in case there are discrepancies regarding eligibility during claims processing.

Medicaid Clients on Passport

Medicaid clients who are covered through Passport do **not** need a referral from their primary care provider to access mental health services. These mental health services will be paid through the Medicaid fee-for-service mental health program. All requirements of the mental health program, including prior authorization, apply to Passport enrollees obtaining mental health care.

Maintenance of Records

All providers of mental health services must maintain records which fully demonstrate the extent, nature, and medical necessity of services provided to Medicaid clients that support the fee charged or payment sought and that demonstrate compliance with applicable requirements. These records must be retained for a period of at least 6 years and 3 months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later (ARM 37.85.414).

The Designated Review Organization, the Legislative Auditor, the Department of Public Health and Human Services, the Department of Revenue, the Medicaid Fraud Control Unit, and their legal representatives shall have the right to inspect or evaluate the quality, appropriateness, and timeliness of services performed by providers, and to inspect and audit all records required by ARM 37.85.414.

Services

Inpatient Hospital

Definition/Requirements

Inpatient hospital services are services provided in an acute care general hospital, acute care psychiatric hospital or a distinct part psychiatric unit of an acute care general hospital. "Inpatient hospital services" are those items and services ordinarily furnished by a hospital for the care and treatment of inpatients. Services must be provided under the direction of a licensed physician, dentist, or other practitioner as permitted by federal law. The hospital must be currently licensed by the designated state licensing authority in the state where the hospital is located and must meet the requirements for participation in Medicare as a hospital.

"Acute care psychiatric hospital" means a psychiatric facility accredited by the Joint Commission on Accreditation of Health Care Organizations that is devoted to the provision of inpatient

psychiatric care for persons under the age of 21 and licensed as a hospital by: (a) the Department; or (b) an equivalent agency in the state in which the facility is located.

"Distinct part psychiatric unit" means a psychiatric unit of an acute care general hospital that meets the requirements of 42 CFR part 412 (2008).

Prior Authorization/Limitations

All inpatient hospital services for psychiatric diagnosis require prior authorization through Magellan Medicaid Administration. If the admitting diagnosis is not psychiatric, but the discharge diagnosis is psychiatric, contact the Children's Mental Health Bureau for retroactive authorization per the requirements of ARM 37.86.2801.

The Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*, including forms to request prior authorized services, is available at the Magellan Medicaid Administration website https://montana.fhsc.com. Click on the *Providers* tab and choose *Youth Program* and either the *Manuals* or *Forms* link. The manual is also available on the Children's Mental Health Bureau website at www.dphhs.mt.gov/mentalhealth/children.shtml.

Billing/Reimbursement

All claims for inpatient hospital services provided to Medicaid beneficiaries must be submitted on a UB-04 form. Payment for inpatient hospital services provided outside the state of Montana will be made only under the conditions specified in ARM 37.86.2801. For further information on service coverage and billing requirements for inpatient services to Medicaid beneficiaries, refer to the Montana Medicaid *Hospital Inpatient* manual at http://medicaidprovider.hhs.mt.gov/.

For assistance completing the UB-04 claim form, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructionsub.pdf.

Outpatient Hospital

Definition/Requirements

Outpatient hospital services are those preventive, diagnostic, therapeutic, rehabilitative, and palliative items or services provided to an outpatient under the direction of a physician, dentist, or other practitioner. Outpatient hospital services must be provided by a hospital licensed as a hospital by the designated state licensing authority in the state where the hospital is located and that meets the requirements for participation in Medicare as a hospital.

Outpatient means a person who has not been admitted by a hospital as an inpatient, who is expected by the hospital to receive services for less than 24 hours, who is registered on the hospital records as an outpatient, and who receives outpatient hospital services other than supplies alone.

Prior Authorization/Limitations

Prior authorization is not required for outpatient hospital services.

Billing/Reimbursement

Outpatient hospital services for psychiatric diagnoses will be reimbursed using the Outpatient Prospective Payment System (OPPS), which is based on the Ambulatory Payment Classification (APC), if applicable, or based on a fee established by the Department for out-of-state hospitals or

in-state Prospective Payment System (PPS) hospitals. For in-state critical access hospitals (CAHs), outpatient hospital services will be reimbursed based on a hospital specific percent of charges. Claims must be submitted on a UB-04 form.

For further information, refer to the Montana Medicaid *Hospital Outpatient Services* manual at https://medicaidprovider.hhs.mt.gov and refer to ARM 37.86.3001 and 37.86.2901.

For assistance completing the UB-04 claim form, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructionsub.pdf.

Partial Hospital Program (PHP)

Definitions/Requirements

A Partial Hospital Program is an active psychiatric treatment program that offers therapeutically intense, coordinated, structured clinical services to a youth with a serious emotional disturbance. These services are provided by professionals at either an acute or sub-acute level of care, and by a licensed hospital.

Full-day programs require provision of services for a minimum of 6 hours per day, 5 days per week. Half-day programs require provision of services for a minimum of 4–6 hours per day, 4 days per week.

PHP must be co-located with a hospital so that in an emergency a patient of the partial hospital program can be transported to the hospital's inpatient psychiatric unit within 15 minutes. Acute level partial hospital programs serve primarily individuals being discharged from inpatient psychiatric treatment and are designed to stabilize youth sufficiently to allow discharge to a less intensive level of care, on generally after 15 or fewer treatment days. Sub-acute level PHP provides, at a minimum, three group and five individual/family therapy sessions per month to provide continued stabilization. Discharge is expected within 60 days.

All partial hospitalization services require prior authorization through Magellan Medicaid Administration Services. When full-day partial hospitalization is requested and authorized, Magellan Medicaid Administration Services will authorize an equal number of full-day and half-day partial hospitalization. This will allow the partial hospitalization provider to bill only for half-day service when the individual can only be present for a half-day session.

Prior Authorization/Limitations

The Department only makes payment for services which are medically necessary as determined by the Department or by the designated review organization. For Medical Necessity information refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*.

Billing/Reimbursement

Claims must be submitted on a UB-04 form. If you need assistance, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructionsub.pdf.

For partial hospitalization services, use Code H0035 with the appropriate modifier.

Service	Procedure Code	Modifier
Acute PHP – Full Day	H0035	U8
Acute PHP – Half Day	H0035	U7
Sub-acute PHP – Full Day	H0035	U6
Sub-acute PHP- Half Day	H0035	—

Reimbursement for partial hospitalization is based on a bundled rate that includes all of the services associated with the psychiatric diagnosis. These services include psychologists, social workers and licensed professional counselors, and medications received during treatment. Physicians and psychiatrists are the only providers allowed to bill separately for their services.

Psychiatric Residential Treatment Facility (PRTF)

Definitions/Requirements

PRTF means a facility other than a hospital, that provides psychiatric services as described in the Code of Federal Regulations, Title 42, Part 441, Subpart D, in an inpatient setting. Services are provided in a secure facility where active treatment is directed at reducing the specific impairments that led to the admission and to provide a degree of stabilization that permits safe return to the home and community setting. Care is provided by psychiatric and multi-disciplinary staff in a licensed, accredited, and certified facility. Ancillary services may be provided in and by the PRTF or outside the PRTF. When ancillary services are provided outside the PRTF, reimbursement for the ancillary services is the financial responsibility of the PRTF. For a list of covered ancillary services, refer to ARM 37.87.1222.

Prior Authorization/Limitations

PRTF services require prior authorization. The Department only makes payment for services which are medically necessary as determined by the Department or by the designated review organization. For Medical Necessity information refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management.*

Billing/Reimbursement

In-state PRTF services are reimbursed a bundled daily psychiatric service rate plus a facility specific ancillary rate. Out-of-state PRTFs are reimbursed 50% of their usual and customary charges, and must include all psychiatric, medical and ancillary services the youth receives.

PRTF Therapeutic Home Visits (THV)

No more than 14 days per individual in each state fiscal year (SFY) are allowed for PRTF therapeutic home visits. All PRTF THV days require prior authorization and must be billed as a THV day. There is a 14-day annual limit to all PRTF THV regardless of how many facilities the youth has resided in during the SFY.

Service	Revenue Code	Modifier
PRTF	124	—
PRTF THV	183	—

Psychiatric Residential Treatment Facilities Assessment Services (PRTF-AS)

Definitions/Requirements

PRTF-AS services are provided in a PRTF as described in the previous section. PRTF-AS is a short-term (14 days or less) intensive PRTF stay targeted at difficult to serve youth. "Difficult to serve" youth means a youth with multiple diagnoses and risk factors who present as "difficult to place." PRTF-AS services are only provided by in-state PRTFs. PRTF-AS services are used to continue the stabilization of youth discharging from an acute hospital setting, to avert an admission to an acute hospital setting or to assess the youth's PRTF specialized treatment needs. PRTF-AS services are for youth who have had multiple acute hospital or PRTF admissions, are at risk of being placed in an out-of-state PRTF, or are difficult to place due to an unclear or conflicting clinical picture.

Prior Authorization/Requirements

PRTF-AS services require prior authorization. The Department only makes payment for services which are medically necessary as determined by the Department or by the designated review organization. For Medical Necessity information refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*.

Billing/Reimbursement

PRTF-AS services are reimbursed a bundled daily psychiatric service rate, which is higher than the regular PRTF rate, plus a facility specific ancillary rate.

Service	Revenue Code	Modifier
PRTF-AS	220	—

Therapeutic Group Homes (TGH)

Definitions/Requirements

Therapeutic Group Home (TGH) services are an out-of-home, community-based treatment alternative appropriate for youth requiring specific treatment interventions and social supports provided in a structured group home environment. TGH are licensed by the Quality Assurance Division of the Department of Public Health and Human Services.

TGH services are appropriate for individuals requiring a higher intensity of specific therapeutic services and/or social supports than are available through traditional outpatient service, and whose needs clearly exceed the capabilities of immediate family, relatives, friends or other community support systems. **TGH room and board costs are not covered by Montana Medicaid.**

Extraordinary Needs Aide (ENA) is a 1:1 aide who may be provided by a TGH for youth with extreme behaviors who need additional supervision and support to be safely maintained in a TGH setting.

Prior Authorization/Requirements

TGH requires prior authorization. The Department only makes payment for services which are medically necessary as determined by the Department or by the designated review organization. For

Medical Necessity information refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*.

To request prior authorization of ENA services, the group home's Lead Clinical Staff must complete the Department's ENA request form and document the medical need for the service. The form may be obtained from the Children's Mental Health Bureau (CMHB) or on the Department's website. The prior authorization form may be either faxed to (406) 444-0230 or mailed to CMHB, P.O. Box 4210, Helena, MT 59604.

Billing/Reimbursement

TGH is reimbursed with a bundled rate that includes the cost of therapies and supervision but not the cost of room and board nor the cost of education. Out-of-state TGH is reimbursed at the same rate as in-state.

TGH Therapeutic Home Visits (THV)

Unless approved by the Department, no more than 14 days per individual in each state fiscal year will be allowed for therapeutic home visits. Because there is a 14-day annual limit, all therapeutic home visits must be billed.

TGH is billed as follows:

Service	Procedure Code	Modifier 1	Modifier 2
Therapeutic Youth Group Home	S5145	—	—
Therapeutic Youth Group Home – Home Leave	S5145	—	U5
Extraordinary Needs Aide Services	S5145	UD	—

Therapeutic Foster Care (TFOC)

Definitions/Requirements

Therapeutic foster care is a home-based treatment alternative for youth with a serious emotional disturbance requiring specific and frequent treatment alternatives and/or social supports. TFOC is provided in a therapeutic foster home. TFOC is appropriate for youth who are unable to live with their biological parents, in kinship care, or in regular foster care, and who require a more intensive therapeutic intervention than is available through traditional outpatient services. **TFOC room and board costs are not covered by Montana Medicaid.**

There are two levels of TFOC: permanency and moderate level. Permanency level TFOC is an intensive therapeutic intervention intended to support a foster placement to become an adoptive home. TFOC is provided by a licensed child placing agency.

Prior Authorization/Requirements

TFOC requires prior authorization. The Department only makes payment for services which are medically necessary as determined by the Department or by the designated review organization. For Medical Necessity information refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*.

Billing/Reimbursement

TFOC is reimbursed daily with a bundled rate that includes the cost of therapies, training and support but not the cost of room and board nor the cost of education.

Unless approved by the Department, no more than 14 days per individual in each state fiscal year will be allowed for therapeutic home visits. Because there is a 14-day annual limit, all therapeutic home visits must be billed.

TFOC is billed as follows:

Service	Procedure Code	Modifier 1	Modifier 2
Moderate Level Therapeutic Foster Care (TFOC)	S5145	HR	—
Permanency Therapeutic Foster Care (TFOC)	S5145	HE	—
Moderate Level Therapeutic Foster Care – Therapeutic Home Leave	S5145	HR	U5

Therapeutic Family Care (TFC)

Definitions/Requirements

Therapeutic family care is a home-based treatment alternative for youth with a serious emotional disturbance requiring specific and frequent treatment alternatives and/or social supports. TFC is provided in an adoptive, kinship, regular foster or biological home. TFC is appropriate for youth requiring a more intensive therapeutic intervention than is available through traditional outpatient services. TFC is provided by a licensed child placing agency.

Prior Authorization/Limitations

TFC requires prior authorization. The Department only makes payment for services which are medically necessary as determined by the Department or by the designated review organization. For Medically Necessity information refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*.

Billing/Reimbursement

TFC is reimbursed daily with an inclusive bundled rate whether or not the family receives services on a particular day. Therapeutic home leave is not available for this service.

TFC is billed as follows:

Service	Procedure Code	Modifier 1	Modifier 2
Moderate Level Therapeutic Family Care	H2020	—	—

Mental Health Center (MHC) Services

Definitions/Requirements

A licensed mental health center (MHC) is a facility providing services for the prevention or diagnosis of mental health issues, the care and treatment of mental health issues, the rehabilitation of individuals with mental health issues, or any combination of these services.

For a mental health center to be licensed, it **must** provide to its clients all of the following services: crisis telephone services, medication management services, outpatient therapy services, community-based psychiatric rehabilitation and support and chemical dependency services. Beyond the required chemical dependency services defined in ARM 37.106.1902, chemical dependency treatment is not reimbursed by the CMHB.

An MHC with the appropriate license endorsement **may** provide one or more of the following services: child and adolescent intensive case management, adult intensive case management, child and adolescent day treatment, adult day treatment, adult foster care, mental health group home, an inpatient crisis stabilization facility, an outpatient crisis response facility, or a comprehensive school and community treatment program. All adult services, mental health group home services, inpatient crisis stabilization facility and outpatient crisis response facility services are not reimbursed by mental health Medicaid for youth. Below is a brief description of youth MHC services reimbursed by Medicaid:

Service	Description
Crisis Telephone Services	**ARM 37.106.1945** defines crisis telephone services. MHCs must ensure that crisis telephone services are available 24 hours a day, 7 days a week. These services must be provided by the appropriately trained individuals under the supervision of a licensed mental health professional. For a full description of service requirements, definitions, and documentation requirements for crisis telephone services, refer to http://www.mtrules.org/gateway/RuleNo.asp?RN=37%2E106%2E1945.
Medication Management	**ARM 37.106.1950** states that MHCs must make medication management services available to the clients it serves for medications needed to treat their mental illnesses. Medication management services shall be provided by licensed health care professionals acting within the scope of their licenses who are either employed by or contracted with the mental health center. For a full description of service requirements, definitions, and documentation requirements for crisis telephone services, refer to http://www.mtrules.org/gateway/RuleNo.asp?RN=37%2E106%2E1950.
Outpatient Therapy Services	Outpatient therapy services means services provided by licensed mental health professionals including psychiatrists, physicians, mid-level practitioners, psychologists, social workers, and licensed professional counselors and in-training mental health professionals. Outpatient therapy services may be provided by an in-training mental health professional who has completed all academic requirements for

Service	Description
	licensure as a psychologist, social worker or licensed professional counselor and who is in the process of completing the supervised experience requirement. In-training mental health professionals cannot enroll in Medicaid and receive reimbursement unless employed by an MHC. In-training mental health professionals must follow the requirements of licensed mental health professionals. Montana Medicaid only reimburses for in-training mental health professional services when billed by a licensed MHC. Outpatient therapy services are subject to the respective requirements of each provider type.
Community-Based Psychiatric Rehabilitation and Support (CBPRS)	This service is provided for a short period of time, generally 90 days or less (unless the youth is in the PRTF waiver) to youth with SED who are at risk of out-of-home or residential placement or risk of removal from their current setting for youth under 6 years of age. CBPRS is provided face-to-face by qualified staff from a licensed mental health center as defined in ARM 37.87.702 and ARM 37.87.703 as part of a comprehensive treatment plan to assist the youth to improve functioning in one or more impaired areas identified in the SED definition. Both individual and group CBPRS is reimbursed in 15-minute units. For limitations, prior authorization requirements, and medical necessity information, refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management.*
Child and Adolescent Intensive Case Management (Targeted Case Management)	See the *Targeted Case Management for Youth with Serious Emotional Disturbance* section of this manual.
Youth Day Treatment	Child and adolescent (i.e., youth) day treatment means a program which provides an integrated set of mental health, education and family intervention services to children or adolescents with a serious emotional disturbance. The child and adolescent day treatment program must be site-based and occur in a location separate from the child and adolescent's regular classroom. For a full description of service requirements, definitions, and documentation requirements for crisis telephone services, refer to http://www.mtrules.org/gateway/RuleNo.asp?RN=37%2E106%2E1936.
Comprehensive School and Community Treatment Program (CSCT)	Comprehensive school and community treatment is provided by a public school district that is either licensed as an MHC or has a contract with a licensed MHC. School-based providers of mental health services must be individually enrolled under the applicable provider types with the specialty of "57" (school) or under the school provider number with the appropriate CSCT cohort. These provider types include licensed psychologists, licensed clinical social workers, and licensed professional counselors. Refer to the CSCT Medicaid manual and relevant ARM for further description and service requirements.

Each MHC shall employ or contract with an administrator and medical director. This requirement does not mean the medical director must be an employee of the MHC or be used on a full-time basis or be present in the facility during all hours services are provided. However, each patient's care must be under the supervision of a physician directly affiliated with the MHC.

To meet this requirement, a physician must see the patient at least once and prescribe the type of care to be provided. If the services prescribed are not limited by the prescription, the physician must periodically review the need for continued care. Although the physician does not have to be on the premises when the patient is receiving covered services, the physician must assume professional responsibility for the services provided and assure the services are medically necessary and appropriate.

Prior Authorization/Limitations

Some mental health center services require prior authorization. Individual and family outpatient therapy services require prior authorization after 24 sessions per state fiscal year, but group therapy and other services such as testing do not require it. The Department only makes payment for services which are medically necessary as determined by the Department or by the designated review organization. For Medically Necessity information, refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*.

Billing/Reimbursement

MHCs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and in-training mental health professionals. Reimbursement will be according to the Department's Resource-Based Relative Value Scale (RBRVS) fee schedule, adjusted for the provider type or the most current fee schedule on the Department's website.

MHC codes are billed as follows:

Service	Procedure Code	Modifier 1	Modifier 2
Crisis Telephone Services	Not a reimbursable Medicaid service for youth.		
Medication Management and Outpatient Therapy Services	Current CPT codes		
Community-Based Psychiatric Rehabilitation and Support (CBPRS) – Individual	H2019	—	—
Community-Based Psychiatric Rehabilitation and Support (CBPRS) – Group	H2019	HQ	—
Child and Adolescent Intensive Case Management (Targeted Case Management)	See the TCM section of this manual below.		
Comprehensive School and Community Treatment Program (CSCT)	H0036	—	—
Child and Adolescent Day Treatment (Youth)	H2012	HA	—

Targeted Case Management (TCM) for Youth with Serious Emotional Disturbance

Definitions/Requirements

Targeted Case Management (TCM) means services furnished to assist Medicaid eligible youth with serious emotional disturbance (SED) in accessing needed medical, social, educational, and other services. TCM for youth with SED must be provided by a licensed mental health center (MHC) with a license endorsement for TCM. Licensed MHCs with this endorsement must enroll with ACS as a TCM provider of mental health services before any case management claims can be paid.

A client may **not** receive two or more types of case management services concurrently. For example, an individual must choose between case management under the home- and community-based services waiver for developmentally disabled children and mental health TCM.

Case management services for youth with SED includes assessment, case planning, referral/linkage and monitoring. Case management services may be provided telephonically.

Prior Authorization/Limitations

Prior authorization is not required for case management services.

Case management services must be supported by narrative documentation of all services provided.

The Department only makes payment for services which are medically necessary. For medically necessity guidelines for TCM, refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*.

Billing/Reimbursement

TCM services for youth with SED will be reimbursed according to the Department's fee schedule.

The Department will pay the lower of the provider's actual submitted charge or the Department's fee schedule for case management services for youth with SED.

Case management services for youth with SED will be reimbursed under the following procedure code by Montana Medicaid. Units must be billed on the CMS-1500 in Block 24d:

Procedure	Modifier	Service
T1016	HA	Targeted case management – Youth, 15-minute unit

For assistance completing the CMS-1500, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf.

Valid ICD-9-CM diagnosis codes must be used in billing the Montana Medicaid program. Failure to use valid diagnosis and procedure codes will result in claims denial**.**

Note: DSM-IV codes are not valid in the Medicaid claims processing system.

Physician Services

Definitions/Requirements

Physician services mean services provided by individuals licensed under the State Medical Practice Act to practice medicine or osteopathy which, as defined by state law, are within the scope of their practice. Physicians can provide mental health services to youth.

Prior Authorization/Limitations

The Department only makes payment for services which are medically necessary as determined by the Department or by the designated review organization. For medically necessity information, refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*.

Billing/Reimbursement

Physicians are required to bill CPT codes for services provided. Reimbursement will be according to the Department's RBRVS fee schedule, adjusted for the provider type.

For assistance completing the CMS-1500, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf.

Physicians are eligible for reimbursement for evaluation and management (E/M) services provided to Medicaid beneficiaries. Use the most current CPT manual for complete descriptions and coding guidelines for E/M services.

A current fee schedule for mental health center physician services is available at http://medicaidprovider.hhs.mt.gov/.

Valid ICD-9-CM diagnosis codes must also be used in billing the Montana Medicaid program. Failure to use valid diagnosis and procedure codes will result in claims being denied.

Note: DSM-IV codes are not valid in the Medicaid claims processing system.

Psychiatrist

Definitions/Requirements

Physicians who practice psychiatry must be board certified or board eligible and licensed by the State of Montana or in the state where they maintain their practice and enrolled as a psychiatrist with Montana Medicaid.

Prior Authorization/Limitations

The Department only makes payment for services which are medically necessary as determined by the Department or by the designated review organization. For medically necessity information, refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*.

Billing/Reimbursement

Psychiatrists are required to bill CPT codes for services provided. Reimbursement will be according to the Department's RBRVS fee schedule, adjusted for the provider type.

For assistance completing the CMS-1500, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf.

Psychiatrists are eligible for reimbursement for evaluation and management (E/M) services provided to Medicaid beneficiaries. Use the most current CPT manual for complete descriptions and coding guidelines for E/M services.

A current fee schedule for psychiatrist services is available at http://medicaidprovider.hhs.mt.gov/.

Valid ICD-9-CM diagnosis codes must also be used in billing the Montana Medicaid program. Failure to use valid diagnosis and procedure codes will result in claims being denied.

Note: DSM-IV codes are not valid in the Medicaid claims processing system.

Mid-Level Practitioners

Definitions/Requirements

Mid-level practitioner services means those services provided by mid-level practitioners in accordance with the laws and rules defining and governing through licensing and certification the practices of advanced practice registered nurses and physician assistants.

Prior Authorization/Limitations

The Department only makes payment for services which are medically necessary as determined by the Department or by the designated review organization. For medically necessity information, refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*.

Billing/Reimbursement

Individual practitioners are required to bill CPT codes for services provided by mid-level practitioners. Reimbursement will be according to the Department's RBRVS fee schedule, adjusted for the provider type.

For assistance completing the CMS-1500, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf.

A current fee schedule for mid-level practitioner services is available at http://medicaidprovider.hhs.mt.gov/.

Valid ICD-9-CM diagnosis codes must also be used in billing the Montana Medicaid program. Failure to use valid diagnosis and procedure codes will result in claims being denied.

Note: DSM-IV codes are not valid in the Medicaid claims processing system.

Psychologist Services

Definitions/Requirements

Psychologist services are those services provided by a licensed psychologist that are within the scope of the practices of the profession as provided for in Title 37, Chapter 17, of the Montana Code Annotated.

Prior Authorization/Limitations

All Medicaid youth with a diagnosis from the current ICD-9-CM can receive an unlimited number of group therapy sessions and up to 24 sessions of individual and/or family outpatient therapy in a state fiscal year. All outpatient therapy claims must include a mental health diagnosis. To receive additional individual and/or family outpatient therapy in excess of 24 sessions, the youth must be determined to have a serious emotional disturbance (ARM 37.87.303).

For medically necessity information, refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*.

Billing/Reimbursement

Individual practitioners are required to bill CPT codes for services. Reimbursement will be according to the Department's RBRVS fee schedule, adjusted for the provider type.

For assistance completing the CMS-1500, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf.

A current fee schedule is available at http://medicaidprovider.hhs.mt.gov/.

Valid ICD-9-CM diagnosis codes must also be used in billing the Montana Medicaid program. Failure to use valid diagnosis and procedure codes will result in claims being denied.

Note: DSM-IV codes are not valid in the Medicaid claims processing system.

Licensed Clinical Social Worker (LCSW) Services

Definitions/Requirements

Those services provided by an LCSW that are within the scope of the practice of the profession as provided for in Title 37, Chapter 2, of the Montana Code Annotated.

Prior Authorization/Limitations

All Medicaid youth with a diagnosis from the current ICD-9-CM can receive an unlimited number of group therapy sessions and up to 24 sessions of individual and/or family outpatient therapy in a state fiscal year. All outpatient therapy claims must include a mental health diagnosis. To receive additional individual and/or family outpatient therapy in excess of 24 sessions, the youth must be determined to have a serious emotional disturbance (ARM 37.87.303).

For medically necessity information, refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*.

Billing/Reimbursement

Individual practitioners are required to bill CPT codes for services provided. Reimbursement will be according to the Department's RBRVS fee schedule, adjusted for the provider type.

For assistance completing the CMS-1500, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf.

A current fee schedule is available at http://medicaidprovider.hhs.mt.gov/.

Valid ICD-9-CM diagnosis codes must also be used in billing the Montana Medicaid program. Failure to use valid diagnosis and procedure codes will result in claims being denied.

Note: DSM-IV codes are not valid in the Medicaid claims processing system.

Licensed Clinical Professional Counselors (LCPC)

Definitions/Requirements

Licensed clinical professional counselor (LCPC) services are those services provided by an LCPC which are within the scope of the practices of the profession as provided for in Title 37, Chapter 23, of the Montana Code Annotated.

Prior Authorization/Limitations

All Medicaid youth with a diagnosis from the current ICD-9-CM can receive an unlimited number of group therapy sessions and up to 24 sessions of individual and/or family outpatient therapy in a state fiscal year. All outpatient therapy claims must include a mental health diagnosis. To receive additional individual and/or family outpatient therapy in excess of 24 sessions, the youth must be determined to have a serious emotional disturbance (ARM 37.87.303).

For medically necessity information, refer to the current Children's Mental Health Bureau *Provider Manual and Clinical Guidelines for Utilization Management*.

Billing/Reimbursement

Individual practitioners are required to bill CPT codes for services provided. Reimbursement will be according to the Department's RBRVS fee schedule, adjusted for the provider type.

For assistance completing the CMS-1500, call Provider Relations or refer to http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf.

A current fee schedule is available at http://medicaidprovider.hhs.mt.gov/.

Valid ICD-9-CM diagnosis codes must also be used in billing the Montana Medicaid program. Failure to use valid diagnosis and procedure codes will result in claims being denied.

Note: DSM-IV codes are not valid in the Medicaid claims processing system.

Pharmacy Services

Definitions/Requirements

The Prescription Drug program covers pharmaceuticals and pharmacist services to clients served by the Department in the Medicaid program and the Mental Health Services Plan (MHSP).

Prior Authorization/Limitations

To request prior authorization, providers must submit the information asked for on the *Request for Medicaid Drug Prior Authorization* form to the Drug Prior Authorization Unit.

The prescriber (e.g., physician) or pharmacy provider may submit requests by mail, telephone, or fax to:
Drug Prior Authorization Unit
Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602

(406) 443-6002 or 1-800-395-7961 (Phone)
(406) 513-1928 or 1-800-294-1350 (Fax)

Requests will be reviewed and approvals or denials will be made, in most cases, immediately. Decisions on requests requiring further peer review because of unusual or special circumstances will be made within 24 hours. Requests received after the PA Unit's regular working hours of 8 a.m. to 5 p.m., Monday through Friday, or on weekends or holidays will be considered to be received at the start of the next working day.

If an after-hours/weekend/holiday request is for an emergency situation, an emergency 72-hour supply may be dispensed by using 3 in the Days Supply field and Medical Certification Code 8 in the PA/MC code field. Payment will be authorized for these emergency supplies.

To receive payment for drugs requiring prior authorization, pharmacies must obtain approval from the Drug Prior Authorization Unit prior to dispensing the drug.

Prescriptions are limited to a 34-day supply. Refills may be dispensed after 75% of a previous dispensing of the same prescription has been used, if taken according to the doctor's orders. Exceptions to this refill rule must be authorized by the Department.

Billing/Reimbursement

Reimbursement information is available in the *Prescription Drug Program* manual.

Billing information is available in the *Prescription Drug Program* manual. If you have questions or experience problems, call ACS Provider Relations:

1-800-624-3958 (In- and out-of-state)
406-442-1837 (Helena)

Copayment
Preferred generic drugs
Preferred brand drugs only with generic available
Brand name drugs with no generic
Generic non-preferred
Non-preferred brand
No copayment for Clozaril and Clozapine

The Medicaid copayments are 5% of the allowable amount between $1 and $5 with a maximum cost share of $5 per prescription and $25 per month.

Preferred products are drugs listed on the formulary for which the State of Montana has a rebate agreement with the drug manufacturer.

Indian Health Services

Indian Health Service providers may be reimbursed for mental health services for Medicaid clients. Indian Health Service providers should bill using the mental health encounter **Revenue Code 513** or the inpatient physician services **Revenue Code 987**.

Federally Qualified Health Centers (FQHCs)

FQHC mental health services are a core service. FQHC providers bill using core services **Revenue Code 900** for mental health services provided to Medicaid clients.

Rural Health Clinics (RHCs)

RHC mental health services are ambulatory services. RHC providers bill using core services **Revenue Code 900**. RHCs must notify the Department **at least** 30 days prior to offering a new category of ambulatory service to their patients. This ensures providers are aware, prior to providing new ambulatory services, of any limits, conditions, reimbursement amounts, etc.

Non-Medicaid Services

Respite care may be billed by a licensed mental health center for up to 12 hours per month (48 units) or 144 hours per year, with no more than 12 hours (24 units) provided in a 24 hour period.

Procedure	Modifier	Service
S5150	HA	Respite

Non-Covered Services

Experimental or investigational services are not covered by Montana Medicaid.

Other Services

The programs listed below will be billed and reimbursed according to their respective manuals for Medicaid eligible individuals, except when the youth is receiving PRTF services. See the PRTF

Service section of this manual and ARM 37.87.1222 for more information on the coverage and reimbursement of other services.

- Ambulance
- Ambulatory Surgical Centers
- Audiology
- Case Management (Non-Mental Health)
- Comprehensive School and Community Services Dental
- Denturist
- Durable Medical Equipment
- Eyeglasses
- Hearing Aids
- Home and Community-Based Services
- Home Health
- Hospice
- Inpatient Hospital
- Laboratory & X-Ray
- Non-Emergency Transportation
- Nursing Facility
- Optometric
- Outpatient Hospital – Emergency Room
- Personal Care
- Physical Therapy
- Podiatry
- Private Nursing
- Public Health Clinics
- QMB Chiropractor
- Speech Pathology
- Swing Bed Hospital
- Transportation & Per Diem
- Family planning

Appendix A: Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions

The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions

The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions

The ASC X12N request for services review and response used for prior authorization.

835 Transactions

The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions

The ASC X12N professional, institutional, and dental claim transactions (each with its own separate *Implementation Guide*).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N

The ANSI-accredited standards development organization, and 1 of the 6 Designated Standards Maintenance Organizations (DSMO), that has created and is tasked with maintaining the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Administrative Rules of Montana (ARM)

The rules published by the executive departments and agencies of the state government.

Adult

A person who is 18 years of age or older. (**Note:** Children's Mental Health continues to cover a person until age 19 who is enrolled in secondary school.)

Allowed Amount

The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors such as cost sharing, TPL, or incurment are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ancillary Provider

Any provider who is subordinate to the client's primary provider or is providing services in the facility or institution that has accepted the client as a Medicaid client.

Authorization

An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Clean Claim

A claim that can be processed without additional information from or action by the provider of the service.

Client

An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)

Rules published by executive departments and agencies of the Federal government.

Community-Based Psychiatric Rehabilitation and Support (CBPRS)

Services provided in home, school, workplace and community settings for adults with severe and disabling mental illness and youth with serious emotional disturbance.

Services are provided by trained mental health personnel under the supervision of a licensed mental health professional and according to a rehabilitation plan.

Conversion Factor

A state-specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Crossovers

Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

Department

The Montana Department of Public Health and Human Services or its agents, including but not limited to parties under contract to perform audit services, claim processing, and utilization review.

DPHHS, State Agency

The Montana Department of Public Health and Human Services (DPHHS or the Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6, MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Experimental

A non-covered item or service that researchers are studying to investigate how it affects health.

Fiscal Agent

ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Gross Adjustment

A lump sum debit or credit that is not claim specific made to a provider.

Hospital

A facility licensed, accredited, or approved under the laws of Montana or a facility operated as a hospital by the state that provides, by or under the supervision of licensed physicians, services for the diagnosis, treatment, rehabilitation, and care of persons with mental disease.

Indian Health Service (IHS)

IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment

A request for a correction to a specific paid claim.

Inpatient Hospital Psychiatric Care

Hospital-based active psychiatric treatment provided under the direction of a physician.

In-Training Mental Health Professional Services

Services provided under the supervision of a licensed practitioner by an individual who has completed all academic requirements for licensure as a psychologist, clinical social worker, or licensed professional counselor, and is in the process of completing the supervised

experience requirement for licensure. The in-training mental health professional services must be supervised by a licensed practitioner in the same field, and, other than licensure, the services are subject to the same requirements that apply to licensed practitioners.

Investigational

A non-covered item or service that researchers are studying to investigate how it affects health.

Mass Adjustment

Request for a correction to a group of claims meeting specific defined criteria.

Medicaid

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people, and the elderly. Medicaid is administered by state governments under broad Federal guidelines.

Medically Necessary

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client.

These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.

There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, course of treatment may include mere observation or, when appropriate, no treatment at all.

Medicare

The federal health insurance program for certain aged or disabled clients.

Montana Access to Health (MATH) Web Portal

A secure website on which providers may view clients' medical history, verify client eligibility, submit claims to Medicaid, check the status of a claim, verify the status of a warrant, and download remittance advice reports.

Passport to Health

The Medicaid primary care case management (PCCM) managed care program where the client selects a primary care provider who manages the client's health care needs.

Patient Day

A whole 24-hour period in which a person is present and receiving inpatient psychiatric services or nursing facility services, regardless of payment source. Even though a person may not be present for a whole 24-hour period on the day of admission or the day of death, such day will be considered a patient day. Subject to the limitations and requirements of ARM 37.88.1106, therapeutic home leave days are patient days. The day of discharge is not a patient day for purposes of reimbursement.

Practitioner

A physician, mid-level practitioner, licensed psychologist, licensed clinical social worker or licensed professional counselor.

Practitioner Services

Services provided by a practitioner which could be covered and reimbursed by the Montana Medicaid program if the individual practitioner were enrolled in the program and provided the services according to applicable Medicaid requirements.

Prior Authorization (PA)

The approval process required before certain services are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-Pay

When a client chooses to pay for medical services out of his or her own pocket.

Provider or Provider of Service

A facility, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.
- A nursing facility or hospital that meets the provider participation requirements specified in ARM 37.88.1405.

Reference Lab Billing

Reference lab billing occurs when a Medicaid provider draws a specimen and sends it to a reference lab for processing. The reference lab then sends the results back to the Medicaid provider and bills the provider for the lab service. The Medicaid provider is then expected to bill Medicaid for the lab service. Medicaid does not cover lab services when they are billed by the referring provider.

Relative Value Scale (RVS)

A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

Relative Value Unit (RVU)

The numerical value given to each service in a relative value scale.

Remittance Advice (RA)

The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Resident

A person admitted to the provider's facility who has been present in the facility for at least one 24-hour period.

Resource-Based Relative Value Scale (RBRVS)

A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Respite Care

Relief services that allow family members who are regular caregivers for a youth with a serious emotional distrubance to be relieved of their caregiver responsibilities for a temporary, short-term period. It is **not** reimbursed by Montana Medicaid except through waivers and the 1915(i).

Retroactive Eligibility

When a client is determined to be eligible for Medicaid effective prior to the current date.

Sanction

The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Third Party Liability (TPL)

Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or HMK client.

Timely Filing

Providers must submit clean claims to Medicaid within the latest of :

- Twelve months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- Six months from the date on the Medicare explanation of benefits approving the service.
- Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Treatment Day

A calendar day, including night, daytime or evening, during which a patient is present at the provider's facility and receiving services according to applicable requirements.

Usual and Customary

The fee that the provider most frequently charges the general public for a service or item.

WINASAP 2003

WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information contact ACS EDI Gateway (see *Key Contacts*).

Youth

A person residing in the state of Montana who is under the age of 18, unless enrolled in secondary school, and then the age is 19.

Appendix B: Index